In The Abstract

A quarterly newsletter from the Kentucky Cancer Registry

UK Cancer Control Leader Part of National Cancer Forum

Steven Wyatt, Associate Director for Cancer Control at the University of Kentucky Markey Cancer Center is participating in the National Dialogue on Cancer, a first-ever national forum of more than 100 cancer leaders. The forum allows leaders from the public, private and non-profit sectors to work together to identify funding for research and develop a new national action plan on cancer. The overall goal is to eradicate cancer as a major public health problem at the earliest possible time. Organized by the American Cancer Society, the forum held its second general meeting in early October. Among the more than 80 participating organizations are the National Cancer Institute, the Centers for Disease Control and Prevention and the Pharmaceutical Research and Manufacturers of America Foundation. U.S. Sen. Dianne Feinstein, D-Calif., is chairperson, and former President and Mrs. George Bush are vice-chairpersons. "The forum members have a sense of urgency about developing legislation that will set new federal cancer policies," Wyatt said. "Our current National Cancer Act did an excellent job of mobilizing our resources to fight cancer, but it was passed 30 years ago. The issues, challenges and opportunities have changed." The forum is divided into nine teams, each focusing on one of the following priorities: public, private and non-profit research, primary prevention, early detection, patient outreach and education, access to health care, access to quality cancer care and a cancer surveillance and data collection system. All the teams are putting emphasis on the high cancer rates among ethnic, minority and medically underserved populations. Wyatt is co-chairing the early detection team with Nancy Brinker, founder of the Susan G. Komen Breast Cancer Foundation. "We will consider how a new National Cancer Act can encourage 'combined' cancer screenings," Wyatt said. "This means doctors can educate patients about several cancer screenings during one visit. For example, when doctors recommend breast cancer screenings, they also should discuss cervical and colorectal cancer tests. We have done well in educating women about mammograms; we need to duplicate that success with other cancers. Our team also will develop strategies to persuade nontraditional allies, such as business employers and health insurance companies, that finding cancer early means significant savings in health care costs," he added. "About 8.2 million Americans alive today have a history of cancer, according to the National Cancer Institute. While overall cancer rates are decreasing, the number of cases is on the rise," Wyatt observed. "This is because our population is growing and aging," he said. "The National Dialogue on Cancer is committed to reversing this trend to the point that cancer is no longer a major health problem." At the UK Markey Cancer Center, Wyatt coordinates a cancer control team that includes the Kentucky Cancer Registry, the Mid-South Cancer Information Service and the Kentucky Cancer Program's Community Outreach Division. The Kentucky team has been nationally recognized for its comprehensive approach to cancer control.

by Suzanne Froelich
Cancer Information Services

KCR TO IMPLEMENT SEER
EXTENT OF DISEASE (EOD) CODING

Beginning with year 2000 cases, KCR will require registrars to code two additional SEER extent of disease fields: Extension and Lymph Node Involvement.

Training to collect these data will be given by April Fritz, CTR on March 13th in Elizabethtown and March 14th in Lexington. (9am - 4pm EASTERN TIME) These sessions are identical and attendance is required at only one session. Enclosed with this newsletter you will find additional information including registration forms.

The reasons for implementing this staging scheme are two-fold:

1) Work is currently in progress at the national level to devise a staging scheme to automatically calculate both the SEER Summary Stage and the TNM Stage based on the SEER EOD codes.

2) The National Cancer Institute's SEER program is expanding its member registries. They have announced a Request for Proposals (RFP) to solicit applications from population based registries who want to become a SEER site. The Kentucky Cancer Registry is considering a response to this request and EOD coding is required for SEER sites.

BITS AND BYTES

- Tammy Ashcraft, CTR at Central Baptist Hospital, has found a very useful web site for searching the Social Security Death Index. It is: http://ssdi.genealogy.rootsweb.com

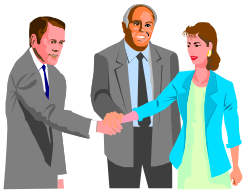
- The 1998 Kentucky Cancer Incidence Report is being printed. Several copies will be distributed to each hospital and the data are now available on the KCR website at http://www.kcr.uky.edu.

  For those who wish to access SEER data at the national level for comparative purposes, particularly in publishing an annual report, the following website is available:

  www-seer.ims.nci.nih.gov
  Click on Publications; select Cancer Statistics Review

- A total of 9 CEU's were awarded by NCRA for the 13th Annual Advanced Cancer Registrars' Workshop "Sailing Into a New Millennium" held at the Galt House, Louisville, September 23 & 24, 1999.

People News



Welcome New Hires

Loretta Parke, University of Kentucky Hospital, Lexington
Candy Robinette, KCR, Administrative Assistant
Becky Bruno, KCR, Regional Abstractor for South-Eastern Kentucky
Mark Combs, KCR, Systems Analyst/Programmer

Resignations

Best Wishes to:

Amybeth Dotson, University of Kentucky Hospital, Lexington
Becky Blevins, CTR, McDowell Regional Medical Center, Danville

Casefinding Audit Results for 1998 cases

The casefinding audit for cancers diagnosed in Kentucky during 1998 showed a noteworthy improvement over the last audit. Although, there is still a greater proportion of cases missed in the small hospitals than in the larger hospitals, both showed improvement in 1998 over the KCR audit of 1997. This is summarized in the table below:

Hospital Group	Number of Cases reported by hospitals in samples		Number of cases missed (annualized)		Proportion of cases missed	
	1997	1998	1997	1998	1997	1998
Small	195	209	52	44	.27	.21
Large	2018	1085	142	20	.07	.02

In order to estimate the number of incident cases missed by reporting hospitals for the entire state in 1998, the following calculations were performed. First, the total number of cases reported by each group of hospitals was determined.

All small hospitals reported 2,365 cases for 1998
All large hospitals reported 22,706 cases for 1998

These totals were then multiplied by the appropriate proportion of missed cases for each group.

Small:	2,365	X	.21	=	497 missed cases
Large:	22,706	X	.02	=	454 missed cases
Total:	25,071				951 missed cases

However, the number 25,071 represents the total number of cases reported to KCR by hospitals, including duplicates of the same patient reported by more than one hospital. The unduplicated case count is actually 19,665 (78% of 25,071). Therefore, the number of missed cases was multipled by 78% to get an estimate of unduplicated missed cases: 951 X .78=742. So the unduplicated missed case estimate is 742 incident cases, missed in KCR by reporting hospitals in 1998, or 3.8%.

During this casefinding audit, KCR found two hospitals had no missed cases for the audit period. We would like to congratulate Cindy Savagian of St. Luke Hospital West in Florence and Leisa Hopkins at the Methodist Hospital of Pikeville for their exceptional efforts in casefinding.

Golden Bug Award

A special thanks to Donna Warwick, CTR, Caritas Medical Center, for identifying another one of those pesky software bugs!

Important Dates in Y2K

February 1 Application deadline for March CTR Exam
Contact National Board for Certification at 913-599-4994 or
National Cancer Registrars' Association at 913-438-6272

February 7-8 CTR Examination Review Workshop Cost: $100.00
Mayo Clinic, Jacksonville, FL
Contact Steven Peace, CTR at 305-243-4602

March 11 CTR Exam Cost: $175 NCRA members $250 non-members

March 13 & 14 SEER Extent of Disease Coding - April Fritz, CTR
13th Hardin Memorial Hospital, Elizabethtown, Ky
14th St. Joseph Hospital, Lexington, Ky

May 9-13 NCRA Annual Educational Conference
Albequerque, New Mexico

June 19-21 Advanced Cancer Registry Training Program
Emory University, Atlanta
Contact: Steven Roffers, CTR, phone: 404-727-4535

August 1 Application Deadline for September CTR Exam

September 14 & 15 KCR Annual Advanced Cancer Registrars' Workshop, Lexington

September 16 CTR Exam

Abstracting Questions & Answers

Question 1: Is there a special rule for coding size (depth of invasion) for melanomas that are smaller than 1.0 mm?

Answer: The general rule, is as follows: code tumors that are ≥ 0.50mm as 1.0mm (00.10 in CPDMS) and those ≤ 0.49mm to 999. (99.99 in CPDMS)
Source: Lynda Douglas, ACoS QA Administrator, Commission on Cancer Newsletter 1999, Vol. 10, #2, p.12.

Question 2: The path report describes a 3.3cm intraductal carcinoma in the UOQ right breast and a 1.6 cm infiltrating ductal carcinoma in the LIQ of the same breast. A. How many primaries does this represent? B. What is the correct tumor size?

Answer: A.) Case represents one primary-the intraductal CA is the in situ component of the invasive ductal CA (ICD-O histology codes 8500/2 and 8500/3). The presence of the 2 separate lesions in different quadrants of the same breast makes no difference since they are of the same histology.

B.) The correct size is 1.6 cm based on the rule to code the size of the invasive component only when a tumor(s) have both in situ and invasive components.
Source: ROADS, Revised 1/1/98, p.121

Question 3: Should G-CSF (growth stimulating factors) be coded as cancer directed therapy?

Answer: No. This is considered an ancillary drug.
Source: ROADS, revised 1/1/98, p.249

Question 4: When the removal of a melanoma is called a "wide excision" and the margin size is not stated, is it appropriate to code surgery at the primary site as 40? If it is called "wide excision" and margins are less than 1 cm; can code 40 still be used?

Answer: You may use code 40 in both instances as it also states: wide excision or re-excision of lesion or minor local amputation (NOS).
Source: ACoS I & R System, 12/99

Question 5: Is it acceptable to pathologically stage a bladder primary when only malignant polyps were removed?

Answer: Total cystectomy and lymph node dissection generally are required for this staging.
Source: ACoS I & R System, 12/99

Per Workbook for Staging of Cancer, 2nd Edition: p.154, #14-Cystectomy is usually not considered a treatment option for Stage 1 bladder cancer so it would be unusual for a Stage 1 bladder CA to be pathologically staged.